Society Reports.

NEW YORK NEUROLOGICAL SOCIETY.

Meeting of May 4, 1886.

C. L. DANA, M.D., President-elect, in the chair.

ADDRESS OF THE RETIRING PRESIDENT.

The address of the retiring president, Dr. W. R. Birdsall, absent through sickness, was read by the secretary, Dr. George W. Jacoby. Dr. Birdsall reviewed the work of the Society for the year, and expressed satisfaction at the number and quality of the scientific contributions and the interest which they had awakened, at the increased attendance of the meetings, and at the harmony which had prevailed in their counsels. He had not shared the fears of those who had believed that the organization of a section in neurology in the New York Academy of Medicine would have a detrimental effect upon the activities of this Society. The year's work had shown that such fears were not well founded ; that this city could support two societies in neurological research without the one detracting from the merits of the other. Both societies had thrived, and the one over which he had the honor to preside had been able to receive one half the number of papers offered. Dr. Birdsall thanked the Society for the honor which it had conferred upon him, and expressed regrets that unavoidable absence deprived him of the pleasure of introducing the President-elect.

INAUGURAL ADDRESS.

Dr. C. L. DANA, the President-elect, recommended to the society that it consider the question of abolishing the custom of having either a retiring or a formal inaugural address unless these be made the means of presenting some scientific question. The

suggestion might also be made whether it would not be wise to limit the membership of the society, or else to establish some qualifications for membership. Dr. Dana said he would call the attention of the members to a large gap which existed in our knowledge of the etiology of nervous disease, and in the need of closer examination into this branch of that specialty. At present our knowledge of the etiology of nervous diseases (leaving out poisons) might almost be summed up: heredity, syphilis, and rheumatism. Was it not possible that neurologists had neglected to apply the ideas with regard to micro-organisms and infection which were now dominating pathology? It was true, however, that Leyden had found a micro-organism in cerebro-spinal meningitis, Rosenbach the bacillus of tetanus, and Strümpell, had urged the view that acute anterior poliomyelitis was an infectious disease, etc.; yet these points were not solidly established, and the relation of infectious poisons or parasites to nervous diseases deserved closer study. It had seemed to him that many cases of the chorea of Sydenham were really infectious in origin. He would also call attention to the possibility of a parasite being at the root of some of the neuro-degenerative disorders, such as ophthalmoplegia externa, bulbar paralysis, and progressive muscular atrophy, The necrobiotic process which took place in these disorders was often so steadily and frightfully progressive, so nearly malignant in the fatal course, as to suggest some active agency behind it.

History of a Case of Primary Labio-Glosso-Pharyngeal Paralysis:

Dr. E. D. FISHER presented a patient whose history was as follows:

Mrs. H., æt. 43, has always enjoyed good health up to July, 1885. At this time she lost her oldest son, who was accidentally drowned. She was much affected by the loss, and was constantly crying and calling for her son. The following September she first noticed some difficulty of speech and inability to move her tongue freely, with also some difficulty in swallowing. Dr. Fisher saw the patient for the first time in February. She then presented the following symptoms: Inability to protrude the tongue beyond the teeth, to form the lips so as to whistle or blow, the lower lip being down, and the saliva ran freely from her mouth. The lower part of her face was expressionless. No loss of power of the upper muscles of the face. The patient was unable to pronounce linguals or labials, and also, as the palate was

partially paralyzed, was unable to pronounce the explosives; all her tones were decidedly nasal. Her food had to be pushed with her hand to the back of her mouth, when with difficulty it was swallowed. There was no tendency for liquids to return through the nose, but they would come out of the mouth. There was no loss of sensation or taste.

The faradic current was somewhat decreased in reaction, but there was no reaction of degeneration to the galvanic current.

These symptoms have all increased since first seeing the patient, and she has lost about twenty pounds in weight. There are no signs of paralysis of the upper extremities; the disease is located entirely in the bulbar nuclei.

The interest of the case lies in the fact that the cause can be clearly traced to the excessive grief at her loss.

Dr. Fisher suggested, in the discussion of the case by the Society, that, recognizing the lesion as seated in the fourth ventricle, involving the hypoglossal, facial, vagus, and glosso-pharyngeal, the question of the situation of the facial nuclei be taken up. Clarke has mentioned that the facial has a lower nucleus for the orbicularis oris, and Gowen thinks that fibres for this muscle are given off from the hypoglossal nucleus. Either of these theories would explain the escape of the upper muscles of the face, as is usual in this disease.

DISCUSSION ON DR. FISHER'S PAPER.

The President said there were several obscure points for discusssion which Dr. Fisher's case had suggested: among others, the question of the etiology of labio-glosso-pharyngeal paralysis, some features in its symptomatology, and its treatment. Regarding the etiology, it was once claimed, he believed, that the disease was always of specific origin. He had had three cases under observation the past two years, and of those only one gave a pretty clear specific history; in the other two, no such influence could be detected at all. In the one, although the patient gave some evidence of having had specific disease, yet it was simply assumption that this was the cause of the bulbar affection. In his opinion, we could only place specific disease among the predisposing causes.

Dr. PUTNAM-JACOBI asked whether the patient had heart disease.

Dr. FISHER replied that the heart had been examined, and no evidence of cardiac disease could be discovered.

Dr. B. SACHS thought the case was one of great interest to all. Bulbar paralysis, he thought, was more common in Europe than in this country ; there was scarcely a clinic at which one or more cases did not present themselves during the year. He had seen a number at the medical clinic at Strassbourg, under Professor Kussnaul. The etiological factor which Dr. Fisher had mentioned, particularly in his own case, deserved consideration. It was further interesting from the fact that the central lesion in this disease, and in diabetes, was near the same region, and that many cases of diabetes had been observed by him in which the etiological factor was intense emotion.

Dr. SACHS thought it was difficult to explain why, in an affection like that from which Dr. Fisher's patient was suffering, in which the pathology was similar to that of progressive muscular atrophy and polio-myelitis anterior, consisting of an affection of the nerve nuclei, there was not the re-action of degeneration in the muscles supplied by the affected nerve nuclei. But it was possible that the action of degeneration would appear later.

Dr. PUTNAM-JACOBI thought the suggestion made by Dr. Sachs as to the analogy between bulbar paralysis and diabetes as far as their possible origin in emotional influences was concerned was worthy of consideration ; and the question had arisen in her mind whether such emotional influence may not have first influenced the cardiac centre in the medulla oblongata and secondarily contiguous centres. Dr. Jacobi spoke of certain anatomical considerations in connection with bulbar paralysis, and referred to several cases reported by Eisenlohr. It seemed to her that exemption of the upper branches of the facial nerve in typical bulbar paralysis was an extraordinary circumstance, and one which she would be glad to have explained. It seemed remarkable that in Dr. Fisher's case the symptoms should have remained so limited for so long a time.

The PRESIDENT had examined the urine for sugar in two cases of bulbar paralysis, but with negative results. With regard to the affection of taste, it is well known that that sense was not usually involved in bulbar paralysis. He had thought that the glossopharyngeal nerve at its nucleus was purely a sensory nerve, and that it received its motor fibres from the spinal accessory ; that it supplied taste to the posterior, and perhaps to the anterior part of the tongue. The question as to whether it supplied general sensation to the fauces or posterior part of the tongue it seemed to

him was involved in considerable obscurity. The cases which he had seen had given no positive evidence that the glosso-pharyngeal nucleus was involved except in one in which there was disturbance of the sense of taste, and there had been two other cases reported in which this sense was involved. With regard to the seventh nerve, and involvement of its nuclei, he thought that in some cases the branches of that nerve were involved. In one of his cases the upper portion of the face was not wrinkled, the eyelids could scarcely be approximated, showing that the facial nuclei were becoming involved. Regarding the reaction of degeneration, it was never present except in the later stages. There might be partial reaction of degeneration at an earlier date. The explanation which he had given was that the trophic centres of the nerve were involved, causing atrophy, to which the paralysis was due.

As to treatment, he thought he should adopt a radically different form from what he had hitherto employed. It seemed to him that the cases improved for a while under electrical treatment, and then such treatment seemed to make them worse. He would give the affected muscles complete rest if possible, and confine the electrical treatment to the stabile galvanic current.

Dr. SACHS remarked that the phenomena of the reaction of degeneration might be present at first only to a limited extent, developing more completely as the case progressed.

Stated Meeting, June 1, 1886.

The President, CHARLES L. DANA, M.D., in the chair.

Trigger Finger (Doigt à Ressort).

Dr. GEORGE W. JACOBY read a paper on this affection, which he said was, strictly speaking, one of a surgical and not of a neurological nature; that is, if its pathology, as at present accepted, was correct. These cases, however, when encountered by the general practitioner, were liable to be referred to the neurologist; hence, the importance of being able to diagnosticate the condition. Doigt à ressort was the name given by Nélaton to a peculiar inhibition of motion in fingers otherwise normal. Flexion and extension were arrested at a given point, and if completed by force, the movement resembled the closure or opening of the blade of a pocket-knife. Sometimes only extension was inter-

fered with. As a rule, muscular effort alone was sufficient to overcome the obstacle. Generally the entire motion was painful, particularly at the time of the snap. The patient usually located the pain in the interphalangeal joint, but a careful examination would show that it was at the metacarpo-phalangeal articulation. Externally the finger presented nothing abnormal, but pressure over the last-mentioned joint almost always produced pain, the painful point being usually confined to a small place upon the volar surface of the flexor tendon. In all cases except those of Busch and his own, a hard lentel-sized body, which was particularly painful to pressure, was found attached to the tendon about two centimetres above the digito-palmar fold. All authors laid stress upon the presence of this body, as it was, according to all theories of the mechanics of this phenomenon, essential to its production. In Dr. Jacoby's first case, he did not remember to have found any nodosity, but as he did not pay particular attention to it, it may have been overlooked. In his second case, however, knowing of the cases of Busch and of Marcano's criticism on them, he made a very careful examination, and could say positively that there was no nodosity or abnormality of any kind discoverable. He saw his first case in 1881, but did not make a diagnosis. The patient was a female servant, who almost continually had her hands in water. She had had vague rheumatic pains for years, but had never had an attack of acute articular rheumatism. About six months prior to her visit to Dr. Jacoby, she began to have a peculiar tingling sensation in the ring finger of the left hand, with shooting pain upward in the arm; she also complained of weakness of the finger and difficulty in flexing it. There was, however, no distinct ressort until two months before he saw her; then she was unable one morning to close the finger, and in attempting to aid herself with the other hand, the finger suddenly snapped shut. Dr. Jacoby saw her only once.

The second case was that of a clerk, aged twenty-eight, whom he saw in November last. The middle finger of the right hand was affected. There was no apparent cause; the patient had never had rheumatism, nor sustained an injury of the finger. The phenomenon came on very suddenly while he was engaged in writing, and was very much fatigued. He made his own diagnosis of writer's cramp, and a physician whom he consulted coincided with this diagnosis. Upon examination, Dr. Jacoby found the peculiar snap to be well marked, and the patient as unable either

to fully extend or flex the finger without the aid of the other hand. Both flexion and extension caused severe pain. Pressure over the metacarpo-phalangeal joint was painful. Repeated and careful examinations failed to reveal the presence of a nodosity or irregularity whatsoever. The treatment consisted in the application of the galvanic current, but, after a few sittings, the patient disappeared from under observation.

The affection had been described and cases published successively by Notta and Nélaton, by Fenerly, Arrachart, Busch, Annandale, Dumarest, Hahn, Menzel, Fieber, Vogt, Blum, Felicki, Herræz, Leisrink, Marcano, and Larheau. The only reference to it which Dr. Jacoby had been enabled to find in any English or American periodical was a translation of Menzel's article, published in the Boston *Medical and Surgical Journal*, 1874, and the description of a case by Annandale, which, however, he evidently did not recognize as a case of doigt à ressort. Dr. Jacoby gave tables of 33 cases by different authors; 21 cases were in women and only 10 in men, in 2 the sex not being specified. All the cases were in adults excepting 2. Occupation seemed not to have any influence in the production of the malady. The fingers affected were the thumb, 16 times; the ring finger, 15 times; the middle, 6; the small finger, twice; and the index finger, only once. In five cases more than one finger was affected. The ætiology must, in the majority of cases, be sought in rheumatism; next in traumatism. In some cases no direct cause could be found. The diagnosis was easy; the prognosis was generally fair, as the symptoms usually disappeared after several weeks of appropriate treatment.

Dr. E. C. SEGUIN said he had never seen a case of true doigt à ressort. He had seen two cases which resembled this condition, but which were of an entirely different nature in their ætiology, They verified the author's statement that such patients were likely to be sent to the neurologist, and he should therefore prepare himself to make a diagnosis. In one of the two cases to which he referred the patient was unable voluntary to flex the terminal phalanx of the thumb, and if it were forcibly flexed it would go back with a jerk. There had been section of the long flexor of the thumb.

Dr. M. A. STARR, who had also seen the second case referred to by Dr. Seguin, said the difficulty, which was due to section of a tendon, had been mistaken for paralysis, but Dr. Seguin cor-

rected the error in diagnosis. A surgeon had sent another patient to Dr. Starr within a week, who at his work was accustomed to make firm pressure with his hand, and suddenly he experienced difficulty in flexing his fingers, being entirely unable to flex the little finger. The faradic current caused flexion of all the fingers but the little one. He sent the patient to a competent surgeon, who made the diagnosis of rupture of the long flexor tendon of the little finger.

Dr. WILLY MEYER had seen two cases of doigt à ressort in Europe. One came to the surgical clinic at Bonn while he was assistant. In both patients the middle finger was affected. One patient was a man, the other a woman. In the case of the man a very thorough examination was made, but no apparent pathological change was present. He was able to use his hand, but with some inconvenience. He wore a splint four or five weeks, which left the finger a little stiff, but this was overcome by prolonged warm baths and passive motion. The woman had complained about two months of pain along the flexor tendon from the middle of the palm of the hand to the tip of the finger, the pain having grown steadily worse. A small painful nodosity was felt just below the metacarpo-phalangeal joint. As there was no doubt that this nodosity was the cause of the affection, they advised its removal, but the patient refused. There were two interesting cases of trigger finger published in the *Centralblatt für Chirurgie* 1884, No. 18.

Dr. Meyer thought there was always a mechanical cause of the disease, for even in those cases in which no particular pathological symptom was observable, there might be something wrong within the articulation. As to treatment, were there no apparent cause for the difficulty, he would use the plaster-of-Paris splint, massage, prolonged hand-bath, passive motion, and perhaps electricity would be advisable. If a nodosity were found it should be removed.

Gilles de la Tourette's Disease.

By C. L. DANA, M.D., and W. P. WILKIN, M.D. (See p. 407)

The PRESIDENT remarked regarding the case that the patient had improved very much under treatment. It was one of the cases in which moral agencies had the power of suppressing the symptoms for a time. The audience had probably observed that while sitting quietly the patient had exhibited a peculiar kind of cough which was about the only thing noticeable.

Dr. GRÆME M. HAMMOND asked whether the boy was cruel.

The President replied, not to his knowledge. The only bad trait which the boy had manifested was the disposition to lie.

Dr. JULIUS RUDISCH thought it probable the disease, as described by Hammond, was the same as that prevailing in Kamtchatka. Persons suffering from acute or chronic belladonna poisoning exhibited this jumping tendency. A further interesting fact was the similarity between the symptoms manifested by this class of patients and those of certain persons sensitive to tickling. Some persons suffering from mental weakness or a mild form of insanity were disposed to pronounce very obscene words, to manifest twitchings of the face and other involuntary movements which they sometimes took pleasure in observing in the mirror. It hardly seemed to him that the description of the case presented to-night accorded with that given by Beard and of those in Siberia and similar ones in Java.

Dr. E. C. SEGUIN thought it might be questioned whether the case presented was like Tourette's cases on the grounds expressed by the author, namely, the different mode of development, the order of development, and the fact that this patient had a defective mind, whereas Tourette's patients had a normal mind. Still, this might be a case in which there was simply an inverse order in the development of the phenomena. He would like to enter a protest against the nomenclature of the disease, especially as it presented no definite clinical history. In some of Tourette's cases there was absence of echolalia or of copsolalia. He preferred Charcot's definition, that of tic convulsiv, which might include quite a variety of jerking affections, or another term embracing all possible varieties of these cases might be employed, as abnormal chorea. An interesting, but almost forgotten, French monograph of about 150 pages on these jerking affections was published at Strasburg in 1850. An interesting case had been reported by a distinguished surgeon of New York.

Dr. M. A. STARR referred to a case related by Dr. Mills, of Philadelphia, in which a tumor involved the second frontal lobe on the left side and pressed upon the third. One of the prominent symptoms was the tendency on the part of the patient to use profane and obscene expressions, apparently without any power to control it. The case suggested the question, why, since irritation of the central convolutions would produce involuntary motion, irritation of the third frontal convolution should not produce involuntary speech.

The PRESIDENT was perfectly aware that the case was one difficult to classify, but he felt positive that if there was such a disease as that pictured by Tourette this patient had it. In one journal which he consulted the name Gilles de la Tourette was given it by Charcot, and he was much surprised to hear Dr. Seguin say that he did not approve of that name. However, he agreed with Dr. Seguin that there were objections to the name. He could not understand how some of the gentlemen arrived at the opinion that the condition in this case was due to insanity, for the boy, although there seemed to be some defect in his mental nature, did not manifest any symptoms of insanity.

THE PHILADELPHIA NEUROLOGICAL SOCIETY.

Stated Meeting, March 22, 1886.

S. WEIR MITCHELL, M.D., President, in the chair.

Dr. H. C. WOOD read a paper on "Landry's Paralysis."

In the course of the paper the symptomatology and diagnosis of neuritis and poliomyelitis were to some extent considered.

Dr. G. BETTON MASSEY said that in regard to pain on pressure in poliomyelitis, that it is of interest to recall the fact that in this affection the skin is unusually sensitive. In children, for a year after the attack, there is hyperæsthesia to tactile impressions and especially to the battery. Hyperalgesia would probably better describe the condition. These cases have presented marked reactions of degeneration, and it has seemed to him that the greater the reactions of degeneration the greater the sensitiveness to the galvanic current in children. An autopsy is by no means necessary to make out the diagnosis, for the clinical histories of these cases are almost identical. It should be as easy to diagnose acute poliomyelitis in a child as to diagnose smallpox. He thought it might be possible in the cases referred to to remove a portion of the nerve for examination during life.

Dr. WHARTON SINKLER, in reply to Dr. Wood's statement that the diagnosis cannot be regarded as proved unless there has been an autopsy, said that we cannot make autopsies in all cases, and we must therefore infer that our diagnosis is correct when the symptoms are identical with those of other cases in which autopsies have been made. Competent observers in this country and abroad have made post-mortem examinations in cases of infantile paralysis, and have found distinct lesions in the anterior horns of the cord. Hence we may assume that there is such a disease as poliomyelitis anterior. He had seen children, as described by

Dr. Massey, in whom there was hyperæsthesia to electricity, especially to the galvanic current.

At least twelve or fifteen years ago Barnwell advanced the view that infantile paralysis was a disease of the peripheral nerves; the later observers, supported by autopsies, seemed to have disproved his theory. Kennedy has described a variety of infantile paralysis under the name of temporary paralysis. We believe that this disease is distinct from "myelitis of the anterior horns," and it may be the result of a diffused neuritis, as suggested by Dr. Wood. He had no doubt that some of the cases of the so-called spinal paralysis of adults, those of short duration, may be of a similar nature.

Dr. FRANCIS DERCUM had lately seen a case in private practice which was of interest in this connection. A man who had been exposed to damp and cold had a chill followed by fever. He was called to see him, and found him suffering with intense pain affecting both brachial plexuses, followed by rapidly developing paresis of both arms. This was evidently a case of peripheral neuritis. The electrical reactions were examined by Dr. Lloyd, who can better give the results of this examination.

In such a case, if the patient does not die early, we may expect the cord to become involved, and then, in the absence of a knowledge of the previous history, it would be impossible for any one to say which was the primary lesion.

He thought it possible that we may have a disease in which both the centres and the nerve trunks are affected simultaneously. Diphtheritic paralysis is probably a case in point.

Dr. JAMES HENDRIE LLOYD thought that the case referred to by Dr. Dercum was of interest, especially with reference to one or two points which had been brought forward in regard to the reactions of degeneration. This man was completely paralyzed in both deltoid muscles, and in the right infraspinatus and the right teres major and minor muscles. The left infraspinatus and teres muscles were perfectly normal. If this was a case of peripheral neuritis, we have facts contradicting some observations made to-night. In this case, typical reactions of degeneration were present. The changes were both serial and modal, and the faradic irritability was almost extinct. There were no fibrillary contractions in this case. In regard to this subject of reactions in wasting muscles, it seems to him that where there have been marked fibrillary contractions, the reactions of

degeneration are not as distinct as we should expect to find them, and this is probably due to the fact that such cases are caused by a slowly advancing anterior poliomyelitis, in which the trophic centres are very gradually destroyed ; whereas, in peripheral neuritis the lesion would be more quickly established, and the characteristic electrical changes would be earlier observed.

Dr. CHARLES K. MILLS thought that while multiple neuritis may occur more frequently than we have been led to think, still, we have as yet few positive diagnostic points. Pain on pressure over a nerve trunk is perhaps one of the best signs of neuritis of all forms, but this is also sometimes found in subacute myelitis of the anterior cells, and in neuralgias there is hyperæsthesia at limited points. In genuine posterior sclerosis at times limited areas of pain on pressure are present. In regard to Landry's paralysis, it seems that subacute myelitis of the anterior horns would simulate it more closely than any thing else.

Some years ago, Leyden advanced the view that locomotor ataxia was due to neuritis, and since then this view has been advocated by different authorities. We find tenderness over the nerves in various spinal and cerebral affections. In some cases of brain tumor, hyperæsthesia is a marked feature. The same is sometimes seen in spinal tumors. It might be said that in these cases there was also neuritis, but in some cases of brain tumor this is impossible. The tumor may be so high as to be remote from the nuclei of origin of the nerves. Leaving post-mortems aside, the uniform bilateral character of many of the cases classed as subacute anterior poliomyelitis is, so far as it goes, in favor of a central origin of the disease.

The suggestion of Dr. Dercum that the disease may simultaneously affect the nerve trunks and the centres, seems more philosophical than to attribute all these cases to multiple neuritis. In arsenical paralysis, he believed that the nervous protoplasm was everywhere affected.

Dr. MORRIS LEWIS read a paper on "The Use of Nitrite of Amyl in the Severe Paroxysms of Whooping-cough."

E. B., female, æt. thirteen weeks ; breast fed ; a well-formed, healthy baby ; rather small, and weighing about seven and one half pounds.

At the age of seven weeks, having just recovered from the effects of a perfectly normal vaccination, she contracted whooping-cough from her brother, whose case had been one of the lightest

character, rendering the diagnosis impossible for over two weeks. The infant's cough for the first week was but slight; but during the second week it began to show the characteristic symptoms.

The child was placed upon a mixture of belladonna and alum every three hours, and progressed favorably until the night of February 12th, which was towards the end of the second week of the disease; it was then seized with a violent paroxysm of coughing, became purple in the face, and finally, according to the mother's statement, ceased to breathe. I was immediately sent for; but before I could answer the summons the mother had thrust the child out of the window into the cool, damp air of a foggy night. This procedure was immediately followed by an inspiratory effort, and the child breathed again. When I arrived the child was in an exhausted state, and was breathing regularly. After this, until the 22d of the month, but one other slight attack of this nature occurred. By this time the child was coughing in a perfectly typical manner. The medicine was continued, but in slightly larger doses, the child taking about the $\frac{1}{12}$ gr. of extract of belladonna in the twenty-four hours.

On the night of the 22d there were three severe paroxysms, during all of which I was present.

The child would awaken with a series of violent expiratory coughs, with scarcely an inspiratory effort between them. Finally, an expiratory spasm would occur, lasting fully fifteen seconds, during which the child would struggle and become perfectly livid. This would be succeeded by complete collapse, with entire suspension of respiration, due probably to exhaustion of the respiratory centre.

During the last two of these attacks I administered ether by inhalation, and believe that thereby the spasmodic stage was somewhat shortened, but the subsequent collapse was so severe that I was obliged to resort to artificial respiration, and once had to continue it for ten minutes, as during that time there were but one or two feeble attempts at inspiration. The evening before I had placed the child on the $\frac{1}{600}$ of a grain of sulphate of atropine every three hours.

Dr. William Pepper then saw the case with me in consultation, and suggested combining a small amount of nitrite of amyl with the ether to prevent if possible the stage of exhaustion. This combination seemed to have a good effect; but, as the amount of ether required seemed to render the child drowsy and

disinclined to nurse, I gradually diminished the proportion of ether until the mixture contained one fourth part of nitrite of amyl. This mixture was kept in a small vial, and with each cough the end of the finger was wetted with the mixture and held close to the child's nose and mouth, so as to catch the first inspiratory effort. Thus administered, the child practically got nothing but nitrite of amyl. After the commencement of this treatment the child never had another attack of exhaustion, and the severity of the paroxysms seemed to be lessened, although the child coughed just as frequently, the number averaging fifty in the twenty-four hours, the amyl being given each time.

No untoward effects were at any time noticed, even when once I held the bottle, containing at least ten drops of amyl, to the child's nose.

It was difficult to judge of the amount of flushing produced by the drug on account of the flushing caused by the cough.

I am confident of the beneficial effect of the nitrite of amyl in this one case, and, although one swallow does not make a summer, I think the drug will be found of use in analogous cases.

Dr. John M. Taylor, who assisted me in watching the case, is also positive of the good effect produced.

In the short time that I have had to look up the literature of the subject, I cannot find that nitrite of amyl has been used in whooping-cough, nor has anybody that I have spoken to on the subject known of its use.

By diluting the nitrite with ether or alcohol it can be administered in any dose required, and could more easily be placed in pearls than the pure nitrite.

By placing it in a bottle with a small top, that can be covered easily by the finger, it can be almost immediately administered by simply wetting the tip of the finger by inverting the bottle.

The child is now doing well, and has had no complication other than a slight umbilical hernia.

Stated Meeting, April 26, 1886.

S. Weir Mitchell, M.D., President, in the chair.

Dr. H. F. Formad, by invitation, read a paper and presented specimens illustrating different forms of "Cerebral Hemorrhage."

Dr. Dercum said that Dr. Formad states that in no case can the blood find its way from the pia mater into the ventricles. That

is true of the general surface of the brain, but not of the base. Profuse hemorrhage at the base may find its way into the lateral and third ventricles through the transverse fissure of the brain ; of this he had seen an instance.

Dr. CHARLES K. MILLS thought that perhaps the statement in regard to the first class of cases may be misleading, if he says absolutely that small hemorrhages in the fourth ventricle and in the lateral ventricle occur only from traumatism. These are of frequent occurrence, particularly in the floor of the fourth ventricle in many diseases. They probably take place at the time of death. He has seen them in cases dying in the epileptic status. They have been found in cases supposed to be hydrophobic.

The occurrence of hemorrhage in the second class of cases opposite the point of application of the force is interesting, and he thinks is best explained by Duret in his papers on traumatisms. He attributes it to displacement of the cerebro-spinal fluid with the formation of numerous vacuoles and the rupture of the blood-vessels from within outward, the largest vacuoles usually occurring opposite the seat of injury. In those cases in which the hemorrhage is in the lenticular body and works its way into the lateral ventricle, numerous ecchymoses occur in various parts of the membranes and of the brain. These occur for the same reason as when the skull is struck from the outside.

He believed that in children hemorrhages occur beneath the pia mater without any special recognizable cause. He has seen one case in which meningeal hemorrhage occurred in a new-born child, probably as result of traumatism from the use of forceps. Where children die soon after delivery, he believes that death is sometimes due to this cause.

Dr. CHARLES K. MILLS reported a case of "Unilateral Sweating."

The patient was an unmarried woman thirty-four years old, sent to him by Dr. Deakyne. Eighteen or nineteen years ago she began to have spasmodic attacks which seemed, from description, to be epileptic. About fourteen years ago she had a stroke of left-sided paresis. About the same time she began to perspire excessively on the side of the paresis. This unilateral sweating has continued up to the present time and is more marked than before. The secretion on the right side is normal. There is also increased lachrymation on the left side. The saliva seems to be about in equal amount on both sides. Before the occurrence of the spasms she complained of a peculiar taste, probable metallic. She occasionally has slight attacks of dizziness, is somewhat

absent-minded, and at one time had severe pain in the head. Four years ago the spasms ceased. The left side of the mouth is visibly drawn a little upward. There is slight paresis of the muscles supplied by the facial nerve. She cannot draw up the left side of the mouth volitionally as well as the right. The slight loss of power in the limbs of the left side is more particularly in the arm.

She has had no trouble with the bladder or bowels. At times the left side of the face reddens very much and remains so for some time. She has some pain on the left side. She has been chiefly treated for uterine trouble. She does not present any signs of the hysterical temperament. Against hysteria are the facts that in the first place, she has paralysis of the muscles supplied by the facial nerve; second, she has contracture on the left side, which is sometimes present in old cases of facial paralysis; and, third, the persistence of the condition for fourteen years.

Dr. EDWARD T. REICHERT thought that it is not only probable that sweat centres exist in the spinal cord, but also that there is a dominant centre in the medulla oblongata. The latter is no doubt bilateral, and while it generally acts as an individual centre, affecting in like degree sweating on both sides, the centre on one side only may be in a condition of over-excitement, as is probably the condition in the present case, thus causing unilateral sweating. The lesion must, he thinks, be above the middle of the pons in order that there may be paralysis of the face and limbs at the same time.

Dr. FRANCIS DERCUM believed that the supposition of some lesion of the cortex going on slowly and leaving a sclerotic patch, and followed by degeneration involving these so-called sweat centres, might explain the case. As regards unilateral sweating, he observed it for four or five years in a case which subsequently terminated in apoplexy. No autopsy was made.

Dr. CHARLES K. MILLS said that Dr. Reichert's remarks would indicate a possible cause for this case. It seemed to him that it might be due to a very small tumor or patch of degeneration of some kind high up in the pons. He found, in looking up the subject, one case of unilateral sweating reported in which degeneration of one of the cervical ganglia was found. He attached but little importance to this. He had recently looked up the subject of unilateral progressive facial atrophy, of which more than fifty cases have now been reported. In a majority of these there has been diminution or entire absence of sweat on the atrophic side